The Habit

ALCOHOL AND DRUG ABUSE DIVISION
MONTANA DEPARTMENT OF INSTITUTIONS
1539 11TH AVENUE, HELENA, MONTANA 59620

SEPTEMBER 1986 - JANUARY 1987

We at ADAD would like to wish you a Merry Christmas and a Happy New Year!

Mark P. Clark
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A BRIEF OVERVIEW OF THE "DRUG ENFORCEMENT, EDUCATION AND CONTROL ACT OF 1986" PUBLIC LAW 99-570

This legislative package of major new initiatives designed to reduce the devastating impact which alcohol and drug abuse have on our nation and its citizens, was passed by Congress and signed by President Reagan on October 27th. These new programs under this Act have been funded to the tune of $1.7 million in new budget authority.

While it is true most of the money will go to drug enforcement and interdiction activities, drug and alcohol education, prevention, treatment and rehabilitation programs are in line to receive close to half a billion dollars this fiscal year. The biggest funding since the inception of the federal drug and alcohol efforts in the early 1970's.

Under Title I, Subtitle K, $230 million each year for FY 87, 88, 89 will be administered to states by Bureau of Justice Assistance (BJA), Department of Justice. Title IV of this bill authorizes new programs for education and treatment. Under Title IV, Subtitle A, $241,000,000 would go to Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) where most of the funds would be allocated to the states for alcohol and drug abuse treatment and rehabilitation (76.5%) and to a new office of substance abuse prevention at ADAMHA (18%) which would combine NIAAA and NIDA prevention activities and administer a new demonstration grant program aimed at high/risk youth. The second major thrust, under Title IV, Subtitle B, is a 3 year alcohol drug abuse education program under the Department of Education, with $200,000,000 authorized this year and $250,000,000 for each of the next two fiscal years.

Under ADAMHA a total of $241,000,000 is authorized this fiscal year only with 70.5% of the appropriated amount going to the states for alcohol and drug abuse treatment and rehabilitation programs and 6% added to and included with this year's distribution under the alcohol, drug abuse and mental health services ADMS Block

Grant. Of the amount earmarked for alcohol and drug abuse treatment and rehabilitation, 45% will be available immediately for distribution to the states on the basis of population, and 55% on the basis of need, under a formula to be determined by the Secretary of Health and Human Services. The new monies are in addition to the FY 87 ADMS Block Grant distribution of $495,000,000, of which roughly half goes for alcohol and drug abuse services on a nationwide basis.

Since this is a very complex bill, we do not know the exact amount of funding for Montana. What we do know so far is that with the 6% addition to the Block Grant Montana will receive $51,000 additional dollars which will bring the total ADMS Block Grant for FY 87 to $2,223,000. Of that amount $ 1,275,335 (57.37%) is available for mental health and $ 947,665 (42.63%) is available for alcohol and drugs.

Based on our most current information that we have received from the National Association of Alcohol and Drug Abuse Directors, there is $162,802,000 available in the new Drug Treatment Block Grant for all states and territories of which 45% will be given to states on population and 55% on need. No state or territory will receive less than $50,000 on the population formula, with Montana estimated to get $249,000 for FY 87 with up to 2 fiscal years to expend it. The additional 55% or $89,540,000 dollars for all states and territories is based on need, with no minimum award guarantee nor is there a maximum amount set. In awarding these funds, the Secretary of the Department of Health and Human Services has to consider the nature and extent of the demand for treatment services; the number of individuals in the state who abuse alcohol and/or drugs and the capacity of the state to provide treatment services; and the ability of the state to provide additional treatment services. It is our belief that the majority of this money will be going to highly populated states which put a very strong emphasis on hard core drugs, such as cocaine, crack, heroin, etc.

Montana is also expected to receive $795,505 under the new Drug Education Block Grant. According to our information, 70% will go to the state education agency (OPI) and 30% to the Governor's office. The 70% ($556,854) will be made available to the state educational agency and allocated to local and intermediate education agencies based on the relative number of school age population within the area. A maximum of 10% may be used for training and technical assistance; development and dissemination of materials; demonstration projects and special financial assistance to areas serving a large number of economically disadvantaged children, sparsely populated areas or to meet special needs. Any monies made available by the state educational agency to local and intermediate educational agencies shall be used for drug and alcohol prevention and education programs including development, acquisition and implementation of curricula; family and school based prevention programs; drug counseling for students and parents; treatment and referral; training; on-site efforts in schools to enhance identification and discipline of drug and alcohol users and special programs for athletes.

Of the 30% ($238,651) made available to the Governor's Office, not more than 50% of the monies shall be used for grants and contracts with local government and other public or private non- profit entities (including parent groups and community action agencies), for the development and implementation of programs and activities such as local, broad based, prevention, intervention, referral and education programs for all age groups; training programs; development and distribution of educational materials; technical assistance in community-based organizations and local and intermediate educational agencies; activities to encourage the coordination of prevention programs with related community efforts, which may involve the use of broadly represented state advisory council; and drug education and prevention activities. Not less than 50% of funds available to be used by the Governor shall be used for innovative community-based programs of coordinated services for high risk youth. The Governor would make monies available through grants and contracts with local educational agencies and other public and private, non-profit entities, including parent groups and community action agencies.

Montana is also expected to receive from the Department of Justice $1,013,000 for a Justice Block Grant program and $325,000 in the discretionary grant program. This discretionary grant program will be administered by the Bureau of Justice Assistance (BJA at the US Department of Justice). The Bureau purposes of this program include providing additional personnel, equipment, facilities, personnel training and supplies for more wide spread apprehension, prosecution, adjudication, treatment and rehabilitative counseling to the drug offenders.

Other significant items in the Drug Enforcement, Education and Control Act of 1986 include:

A. Treatment evaluation.

The Secretary of the Department of Health of DHHS through ADAMHA is authorized to carry out, develop and evaluate alcohol and drug treatment programs to determine the most effective forms of treatment;

B. Veterans Administration.

The Veterans Administration is eligible to receive a transfer of funds for outpatient treatment, rehabilitation and counseling of veterans for alcohol and drug dependency or disabilities. These monies may also be used by the VA for contract care and services and half-way houses, therapeutic communities, psychiatric residential treatment centers and other community-based facilities.

C. Office of Substance Abuse Prevention

The Office of Substance Abuse Prevention (OSAP) is authorized within ADAMHA which is to be headed by a Director appointed by the Secretary. The Director is requested to sponsor regional workshops on prevention of alcohol and drug abuse; coordinate research findings on prevention; assure widespread dissemination of prevention materials; support clinical training of counselors and other health care professionals; work with the Director of Center for Disease Control in the development of materials to reduce the risk of AIDS among intravenous drug users; support the development of model community-based prevention programs; and prepare documentary and public service announcements for television and radio.

D. Model projects for high risk youth.

Demonstration grants are authorized to be made available to public and non-profit private entities for projects to demonstrate effective models for the prevention, treatment and rehabilitation of high risk youth.

As of December 10, ADAD has applied to ADAMAHA for the new alcohol and drug treatment levels under Title IV, Subtitle A. Again, we presently only know the 45% amount of $249,000: Montana's share of the 55% allocation probably will not be known until February. Authority to expend these funds will be presented to the upcoming Legislature during ADAD budget appropriation hearings.

If you have any questions concerning these funds please feel free to contact ADAD.

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In 1985, for the first time, data were gathered about the ways cocaine was used. Sniffing cocaine is by far the most popular route of administration: 95% of the cocaine users reported taking cocaine by this route. While overall only 8% of the cocaine users reported ever taking the drug intravenously, the relationship of intravenous drug use to AIDS highlights the need to reduce the use of this route of administration even further. Youth (3%) were least likely and older adults (13%) were most likely to have taken cocaine intravenously.

Forty-four percent of youth using cocaine have smoked the drug, as compared to 21% of young adults and 19% of mid-adults (age 26-34). Furthermore, 38% of those who had used cocaine in the past month report having smoked cocaine, as compared to 10% of those who had used cocaine more than a year ago. (These data were collected in 1985 and do not fully reflect the use of crack, which did not appear nationally until late 1985). Because of the rapid and short duation of effects, smoking freebase is dangerous and results in the rapid development of drug dependency.

From: Nida Capsules, Nov. 1986

Below are the results of the survey printed in the last Habit publication. We had a terrific response!

Thank you to Phyllis Burke for compiling all the data, it was a lot of work.

MONTANA DEPARTMENT OF INSTITUTIONS
ALCOHOL AND DRUG ABUSE DIVISION

MONTANA SURVEY RESULTS

1. Would you favor or oppose a state law that would raise the legal drinking age to 21?

Age	Number of (Respondents)	Favor	Oppose	No Opinion
15-17	(100)*	12%	79%	9%
18-20	(50)**	26%	66%	8%
	(310)***	81%	15%	5%
	(288)***			
0-19	(8)	25%	50%	25%
20-29	(77)	66%	23%	10%
30-39	(92)	84%	14%	2%
40-49	(59)	85%	14%	
50-59	(34)	88%	12%	
60+	(18)	94%		6%

2. Would you favor or oppose a law that would withhold some federal highway funds from states with minimum drinking ages below 21?

Age	Number of (Respondents)	Favor	Oppose	No Opinion
15-17	(100)*	6%	85%	9%
18-20	(50)**	12%	80%	8%
	(310)***	41%	50%	9%
	(293)***			
0-19	(6)	17%	83%	
20-29	(76)	29%	62%	9%
30-39	(94)	50%	44%	6%
40-49	(64)	52%	42%	6%
50-59	(35)	43%	46%	11%
60+	(18)	28%	56%	17%

(* Helena High School)
(** Carroll College)
(*** Statewide Survey)

3. Recently the New Jersey Supreme Court ruled that hosts can be sued for injuries to victims of auto accidents caused by adult guests to whom the hosts have served alcoholic beverages. Would you like to see such a law in Montana or not??

Age	Number of (Respondents)	Favor	Oppose	No Opinion
15-17	(100)*	17%	79%	4%
18-20	(50)**	14%	80%	6%
	(310)***	17%	76%	7%
	(289)***			
0-19	(6)	50%	50%	
20-29	(76)	8%	80%	12%
30-39	(93)	19%	77%	3%
40-49	(60)	25%	70%	5%
50-59	(36)	17%	69%	14%
	(18)	28%	72%	6%

4. In some communities a minor who is apprehended at a keggar is guilty of possession regardless if that minor is using/drinking. Do you favor this concept or not?

Age	Number of (Respondents)	Favor	Oppose	No Opinion
15-17	(100)*	5%	93%	2%
18-20	(50)**	14%	82%	4%
	(310)***	34%	56%	10%
	(287)***			
0-19	(6)	83%	17%	
20-29	(76)	21%	64%	14%
30-39	(92)	45%	46%	10%
40-49	(59)	37%	53%	10%
50-59	(35)	40%	57%	3%
60+	(19)	26%	68%	5%

(* Helena High School)
(** Carroll College)
(*** Statewide Survey)

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Overall, 70.4 million Americans age 12 or older (or 37% of the population) have tried marijuana, cocaine or other illicit drugs at least once in their lifetime.

Nineteen percent of the household population aged 12 years and older (36.8 million people) have tried marijuana, cocaine or other illicit drugs at least once in the past year and 23 million people (12%) at least once during the month prior to being surveyed in the 1985 National Household Survey on Drug Abuse.

From: NIDA CAPSULES Nov. 1986

A.C.T. PROGRAM EVALUATION

By Mark Clark

The ACT Program has become established across the state now, with most of the programs having received their first evaluation of the ACT component. Generally the implementation of the system seems to be going smoothly, however there have been certain areas of confusion common to many programs. In this article I will identify the most common problem areas found in the evaluations.

1. Required Policies and Procedures.

47% of the programs were missing partial ACT policies and procedures which address all services provided and staff requirements. The following policies and procedures must be present: 1) description of the 3 level process, 2) policy on screening, assessment and evaluation which identifies the assessment and screening tools utilized and the process used, 3) admission and discharge procedures which identify timelines, 4) an outline of the educational component which references the ACT curriculum manual and identifies the number of sessions provided, 5) procedures for the evaluation/recommendation report which includes a copy of the report form and identifies the date it is sent to the court, 6) referral procedures for level III, if appropriate, which ensure verification of a successful referral and transfers the responsibility of informing the court of non-compliance, 7) a policy on staff requirements, 8) procedures for determining cost and fees charged for the ACT Program, 9) goals and objectives which address required effectiveness indicators (i.e., ACT caseload, completion ratios, percentage of offenders recommended for treatment, percentage of offenders who enter treatment, and percentage of repeat offenders), 10) maintenance of an ACT Program log.

2. Demonstration of Effectiveness

Most programs were not scored on the demonstration of effectiveness item this year but this will be a priority for next year's evaluations. After establishing effectiveness indicators the program must report their progress to their Board of Directors. At the time of the evaluation the program must be able to demonstrate the accomplishment of the required effectiveness indicators.

3. Presence of all Required Forms

When a program is evaluated a sample of active ACT program files from the test month are reviewed. This includes, initial and repeat offenders as well as non-compliance files. The following items must be present: 1) ADAD Admission/ Discharge report, 2) Assessment/evaluation instruments used with evidence of cross-referencing (41% of the programs were lacking this), 3) documentation of educational sessions, offender entrance and exit interviews/ tracking summary and counselors observations and conclusions. (53% of programs were missing documentation), 4) Evaluation/recommendation report which includes all required items (53% of programs were missing this), 5) Court sentencing orders, 6) Signed release of confidential information forms to the sentencing court, and Driver's Improvement, 7) Documentation of non-compliance (where applicable), 8) Fee charges and documentation of ability to pay.

4. Timelines

The evaluators interview staff members responsible for the ACT Program and review the ACT log and policy to determine compliance with timelines. The program must notify the sentencing court and Driver's Improvement if the offender does not enroll (make contact) with the program within ten days or start the course process within 30 days of the program's receipt of the court referral notice. Level I and II of the ACT Program will take not less than 30 days nor longer than 90 days to complete.

5. Non-Compliance

In the case of non-compliance the sentencing court must be notified. We recommend the non-compliance affidavit for this purpose. The program may use other forms which are acceptable to their local authorities. Driver's improvement must also be notified stating only that the client is "not in compliance". No confidential information should be mailed to them.

When an offender is discharged for non-compliance, an ADAD Discharge report

needs to be completed showing that they did not complete the process. If the offender returns (for the same offense) to the ACT Program a corrected copy should be made with the same admission information and providing the new discharge information.

6. Admission/Discharge Reports

A new category has been added this year to item #20 "Reason for Discharge" on the DUI Admission/Discharge Report. Number #4. "Referred to Treatment", can be written in for those offenders who enter Level III. At that time they should be discharged from the ACT Program and admitted on a regular treatment admission form.

7. Offender Logs

The programs must develop and utilize their own offender logs. These must be kept current as the data is needed for monthly and quarterly reports. The following services and data should be monitored as they occur for each offender. Name, case number, referent, admission date, date of initial interview, dates of classes #1, #2, #3, #4, attended, court notified of non-compliance date, date of exit interview, fee paid date, number of previous DUI's, assessment results/classification, discharge date, where referred, documentation of successful referral, and comments. This data would be very useful for documentation of effectiveness. It would also be an easy way to identify the number of admissions, discharges and active clients for the monthly report.

These are some of the areas that were covered in the October DUI/ACT training workshops regarding administration of the ACT Programs. As the counselors, programs and communities become more familiar with the process these problems will be alleviated. In general, the programs have done well in implementing these new standards and the process appears to be working well. For further information or clarification please call the Standards and Quality Assurance Bureau of ADAD at 444-2827.

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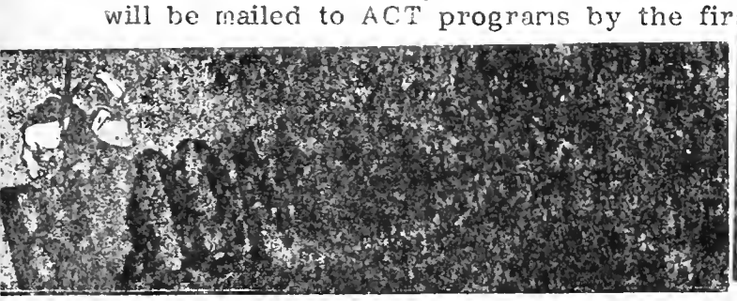
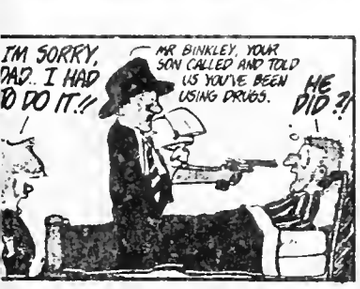
The nonmedical use of psychotherapeutic drugs: sedatives, tranquilizers, stimulants, and analgesics is not common. For sedatives, there was decreased nonmedical use in all age groups, the only two statistically significant changes, however, occurred in the 18-25 age group. First, the percent of 18-25 year-olds who have ever taken a sedative for a nonmedical reason decreased from 19% in 1982 to 11% in 1985. And secondly, there was a significant decline in the nonmedical use of sedatives in the past year, from 8.7% in 1982 to 5.1% in 1985. Nonmedical use of stimulants declined among the two younger age groups but none of the changes were statistically significant.

From: NIDA Capsules, November 1986

An advanced ACT seminar is now in the planning stages. It will be held April 15, 16, 17 at the Great Falls Sheraton. The seminar will be sponsored by the Missoula County Health Department and Montana Highway Traffic Division. Pam Anderson of Recovery Foundation is developing the agenda. Detailed information will be mailed to ACT programs by the first of March.





DUI CHARACTERISTICS REPORT FOR FY 86

[These statistics are based on the forms that are sent to ADAD monthly. All percentages are rounded off.]

Based on a total admission of 4,125.

SEX

Male	82%
Female	18%

AGE

0-17	1%
18-20	9%
21-25	23%
26-30	19%
31-44	30%
45-64	15%
65+	3%

RACE

White	86%
Black	less than 1%
Native American	12%
Hispanic	1%
Other	1%

MARITAL STATUS

Never married	44%
Married	30%
Separated	4%
Divorced	20%
Widowed	2%

EMPLOYMENT STATUS

Full/part time	64%
Unemployed	24%
Other	6%
Student	7%

COURTS

District	1%
Tribal	2%
Municipal/City	53%
Justice of Peace	42%
Out of State	2%

BAC CONTENT

.05 - .09	1%
.10 - .20	72%
.21 - .30	26%
.31 - .40	1%

PREVIOUS DUI CONVICTIONS

0	78%
1	19%
2	3%
3	1%
4	less than 1%

PREVIOUS DUI SCHOOLS

0	84%
1	15%
2	1%
3	less than 1%

PREVIOUS TREATMENT

Yes	11%
No	89%

REASON FOR DISCHARGE

Completed school	86%
Did not complete	11%
Transferred	3%

RESULTS ASSESSMENT/EVALUATION

Misuse/no problem	30%
Abuser	28%
Dependency	33%
Unidentified	9%

TREATMENT RECOMMENDATION

None	61%
Yes - outpatient	26%
Yes - inpatient	13%

REFERRAL - COURT SCHOOL

None	42%
Own program	23%
Other program	10%
AA, Al-Anon	8%
Courts	11%
Mental Health	less than 1%
Hospital/MD	1%
Other	less than 1%

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A health warning label about drinking during pregnancy based on the Surgeon General's admonition to pregnant women not to drink, would strengthen currently available "awareness" materials on the potential dangers of drinking during pregnancy, would encourage physicians and other health professionals to provide compatible messages to their patients, and would alert women, including low-income women, many of whom lack access to medical and pre-natal care, to the hazards of drinking during pregnancy.

From: CSPI - July, 1986

The adverse consequences of moderate drinking are well-documented. They include a heightened risk of getting cancer of the mouth or pharynx (especially when combined with smoking); an increased risk of hemorrhagic stroke; and serious complications when combined with a wide range of prescription and over-the-counter drugs.

From: CSPI - July, 1986

Non-auto accidents involving alcohol claim over 25,000 lives each year. Up to 40% of industrial accident deaths are alcohol related; up to 68% of drowning deaths, 70% of falls, and half of all fire deaths are tied to alcohol use.

From: CSPI - July, 1986

SHOULD THE LEGAL LIMIT OF INTOXICATION BE LOWERED?

[As printed in the DUI Tieline, November/December, 1986]

Ethyl alcohol, the type of alcohol found in alcoholic beverages, impairs sensory and motor functions - functions which are necessary to operate a motor vehicle. At what point is an individual incapable of safely operating a motor vehicle? In 1960, the House of Delegates and Board of Trustees of the American Medical Association suggested that a blood alcohol concentration of 0.100% be accepted as evidence of alcoholic intoxication, even though many individuals may be intoxicated at alcohol levels below 0.100%. According to an article published in the March 1985 issue of Pathologist, there does appear to be some evidence that the majority of drivers who have consumed alcohol are impaired at blood alcohol levels below 0.100%. In the article which is entitled, How Valid is the 0.10 Percent Alcohol Level as an Indicator of Intoxication?, the authors, Dr. V.J.M. DiMaio, M.D. and Dr. J.C. Garriott, Ph.D., review the results of scientific studies investigating the effects of alcohol upon driving skills. Based upon their findings, they make the suggestion that the "legal limit of intoxication" should be lowered.

Driving is a complex process that requires the interaction of motor and sensory functions. One very important skill for driving is reaction time, which is the time it takes for an individual to respond to a stimulus such as a red light. The effect of alcohol is to increase the reaction time. The results from a number of studies indicate that reaction responses are impaired at blood alcohol levels above 0.07%. In one particular study, blood alcohol concentrations ranging from 0.012 to 0.12 resulted in 5 to 17% increases in reaction times.

Studies in which each visual sensory function was tested separately indicate that alcohol impairs visual functions. The visual functions tested included peripheral vision, glare recovery, and flicker fusion. A better method of studying alcohol's effects would be to test visual functions in combination with motor functions. In one study, the ability to detect intermittent visual signals was combined with a tracking task. Individuals with blood alcohol concentrations of 0.05% and 0.100% detected, respectively, 10% and 20% fewer signals than individuals who did not have any alcohol to drink. Interestingly enough, those individuals who detected fewer signals did so because they failed to see the signals.

Tracking skills are associated with the operation of a car. A driver must be able to track, search, and recognize objects that appear in his or her visual field. Compensatory tracking is impaired only at high blood alcohol levels, whereas pursuit tracking is impaired at blood alcohol levels of 0.05% to 0.09%. Pursuit tracking is representative of the demands required of a driver. According to the authors, because pursuit tracking requires more processing of information than other forms of tracking, it is affected at lower blood alcohol concentrations.

Attention can be divided up into several types. Alcohol apparently does not affect concentrated attention. However, divided attention is involved in driving and it has been shown that the ability to shift attention from one thing to another can be impaired at blood alcohol levels as low as 0.05%.

Driving involves visual and tracking responses. It is a complex process that involves a tremendous amount of information processing. According to the authors, alcohol impairs driving skills by affecting the ability to process information. The scientific evidence seems to suggest that significant impairment of driving skills starts to occur at blood alcohol concentrations of 0.05%. Therefore, the authors feel that the blood alcohol level used to indicate intoxication should be reduced to a value that is closer to 0.05%.

- Drinking/Driving Law Letter

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Slightly more than half (56%) of the youth have tried an alcoholic beverage at some time in their lives. Use in the past year (52%) is almost as high; and 32% have consumed at least one drink during the past month. Among young adults, the figures are substantially higher: 93% had tried alcohol, 87% had used alcohol in the preceding year, and 72% had used alcohol during the preceding month.

From: NIDA Capsules
November 1986

DUI LAWS IN OTHER COUNTRIES TOUGHER THAN UNITED STATES

[From the Office of Dr. Terrence E. Schonburg, clinical director of the Karlsruhe Community Counseling Center. Reprinted from the Banner.]

Turkey: The driver is taken 20 miles from town by police and forced to walk back under escort.

Bulgaria: A second conviction is the last. Punishment is execution.

San Salvador: The driver is executed by firing squad.

Finland, England, Sweden: The driver is automatically jailed for up to one year.

South Africa: The driver is given a 10-year jail sentence, a fine of $10,000, or both.

Australia: Names of convicted drunk drivers are published in local newspapers under "drunk and in jail."

Malaya: The driver is jailed. If he or she has a spouse, the spouse is also jailed.

From: Montana Motorist, Dec. 1986

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CHEMICAL DEPENDENCY PROGRAMS OF MONTANA CORNER

Due to the resignation of Harold Schutt as president of CDPM, Mike Ruppert was elected president and Ken Anderson as vice president. Doug Settles remains in the secretary/treasurer position. Ron Luchau was elected as the counselors' representative.

The primary legislative issues that CDPM wishes to address in the 1987 Legislative Session are the following:

Certificate of Need (CON) is sunsetting June 30, 1987 and CDPM wants this process to continue. Legislation will be introduced to extend the date of the CON.

The raising of minimum insurance coverage which would include chemical dependency under major medical.

The Missoula Crime Lab presently receives an allocation from earmarked funds. CDPM would like the crime lab to receive funding from the DUI fines.

These issues were discussed and are presently in the initial stages of planning.

CDPM is actively seeking counselors to join the organization. If you are interested please contact either Mike Ruppert (586-5493) or Doug Settles (449-7630).

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Lifetime use of cocaine among youth (age 12-17) and young adults (age 18-25) decreased from a high of 6.5% and 23.3% in 1982 to 5.2% and 25.2% rspectively in 1982. The percent of older adults (age 26+), who had tried the drug, however, increased by a full percentage point to its highest rate, from 8.5% to 9.5%.

The nonmedical use of psychotherapeutic drugs: sedatives, tranquilizers, stimulants, and analgesics is not common. For sedatives, there was decreased nonmedical use in all age groups, the only two statistically significant changes, however, occurred in the 18-25 age group. First, the percent of 18-25 year-olds who have ever taken a sedative for a nonmedical reason decreased from 19% in 1982 to 11% in 1985. And secondly, there was a significant decline in the nonmedical use of sedatives in the past year, from 8.7% in 1982 to 5.1% in 1985. Nonmedical use of stimulants declined among the two younger age groups but none of the changes were statistically significant.

From: NIDA Capsules, Nov. 1986

COKE USERS ARE LOOKING MORE LIKE OTHER DRUG ADDICTS

Washington - Cocaine's increasing affordability and availability has changed the psychological profile of those at risk of becoming abusers, says a team of Massachusetts doctors.

They told the annual meeting here of the American Psychiatric Association that cocaine abusers are now more closely matched in terms of psychopathology to other drug dependent patients.

Traditionally, a high percentage of cocaine abusers were diagnosed as suffering from affective disorders such as major depression, narcissistic and histrionic behavior, hyperactivity, inflated self-esteem, and irritability.

However, as cocaine use has become more widespread, "the prevalence of affective disorders among cocaine abusers decreased significantly to 29.7% in 1982/84, from 53.3% during 1980/82."

The study, by researchers from the Alcohol and Drug Abuse Research Center, McLean Hospital, Belmont, Massachusetts, and the Department of Psychiatry, Harvard Medical School, Boston, examined a sample of 94 hospitalized cocaine abusers and compared them with 219 hospitalized patients dependent on opiates or central nervous system depressants.

Psychological testing showed the cocaine abusers had higher rates of affective disorders than the other drug-abuse patients and that an affective disorder was also more common among first-degree relatives of cocaine abusers. But, the researchers said: "In looking at drug use trends over time, we found that the differences between the two groups are narrowing."

In addition, they said anti-social personality disorder, which earlier investigations found to be confined almost exclusively to opioid addicts, is becoming more common among cocaine-dependent patients.

The Massachusetts team identified three major subtypes of chronic cocaine abusers in the sample:

- patients with major depression or attention deficit disorder, who may initially use cocaine as a form of self-medication;
- patients prone to mood swings (cyclonic or bipolar disorders), who use cocaine primarily when euphoric or hyperactive to prolong these states; and,
- patients with characterological problems (such as anti-social personality disorder), for whom cocaine use serves their own particular psychological or interpersonal needs.

They suggested different treatment strategies be used for the varying subgroups of cocaine abusers.

From: U.S. Journal - October 1, 1986

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Compared with 1979 and 1982 levels, the 18-25 year-old-group was most likely to have stablized or decreased their use of most drugs in 1985. In contrast, the 26 year-old age group was most likely to have increased their use of most drugs. The increase in this age group is at least partially explained by the aging of individuals who began using drugs in previous years.

From: NIDA Capsules, Nov. 1986

Current use of cocaine (past month use) increased from 4.2 million in 1982 to 5.8 million in 1985. This represents an increase in rate of use from 2% of the household population aged 12 and older in 1982 to 3% in 1985.

From: NIDA Capsules, Nov. 1986

COCAINE HOTLINE (1-800-662-HELP)

During the first six months of operation, the hotline has received over 12,000 calls. However this is an average, the rate of calls has increased from 1,000 a month initially to the present 3,000 a month. Currently, 200 to 250 calls are answered each day. From a sampling of the calls, NIDA found that about half were calling for themselves; the rest were calling because of their concern about the drug use of their relatives and friends. Most users are over 18. We have received calls from all States, including Alaska and Hawaii. A disproportionate number have come from New York, California and Florida. This may reflect both the extent of cocaine use in these States, as well as their broadcasters' willingness to air the cocaine campaign materials. Since the number is currently associated with the cocaine campaign, most callers are cocaine users and other drug abusers, as well as concerned friends and family. In the future, the line will be incorporated into an AIDS campaign to educate and inform intravenous drug users of their risks and encourage them to get treatment. It will also be advertised in other NIDA public education materials as a referral source.

The line is currently staffed between the house of 9 a.m. to 10 p.m. on Mondays, 9 a.m. to 7 p.m. Tuesday through Friday, and noon to 6 p.m. on the weekends. Within the next several weeks, the hours will be expanded to 9 a.m. to 3 a.m. weekdays and noon to 3 a.m. on the weekends.

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US SURVEY SHOWS 30% OF COKE USERS
HAVE TRIED INTRAVENOUS ADMINISTRATION

By Harvey McConnell

Washington - Cocaine use in the United States continues to rise, as does the number of people who report serious problems with it.

At the same time, use of marijuana, LSD and PCP, and other drugs continues to decrease, says the US government's eighth national household survey on drug abuse. The survey has been carried out periodically since 1971 by the National Institute on Drug Abuse (NIDA).

In overall terms, 36.8 million people age 12 years or older reported having tried marijuana, cocaine or other illicit drugs at least once in 1985, and 23 million report having tried illicit drugs at least once during the month prior to the survey.

The number of current cocaine users climbed to 5.8 million in 1985, compared with 4.2 million in 1983.

At a press conference, Ian Macdonald, M.D., administrator of the US Alcohol, Drug Abuse and Mental Health Administration, said one of the most interesting findings is the route of administration of cocaine.

Virtually all cocaine users (95%) have tried snorting the drug. Experts are particularly concerned about the 80% who have used the drug intravenously because of the threat, through needle sharing, of AIDS (acquired immune deficiency syndrome), and the 21% who smoked freebase forms of cocaine.

Dr. Macdonald, "Especially disheartening is the finding that 44% of youth who have used cocaine have smoked freebase. For young adults, this number is 21%, and for those 26 to 34 years old, it is 19%."

Dr. Macdonald said those reporting marijuana use in the past month decreased to 10% in 1985, compared to 11% for 1982.

"Even though there was an overall decrease in marijuana use, we are disheartened to find six million people reported they use marijuana almost daily.

"Among youth ages 12 to 15, 2% of males and 1% of females who have tried marijuana had used it at least 100 times.

"Among young adults aged 18 to 25, there was an even higher percentage. 36% in males and 24% in females who tried marijuana used it 100 or more times".

US Survey (continued)

The survey found more than 60 million people are current cigarette smokers and the relationship between drinking, smoking and the use of other drugs is marked.

Dr. Macdonald said the survey shows "in many ways, we are making progress in the fight against drug abuse. However, we have a very long way to go."

He added that the statistics on cocaine use and the number of users seeking treatment show "it is very difficult for a user to control and more and more of those who have been users will need treatment."

Charles Schuster, PH.D., NIDA director, said the institute is now carrying out a number of research initiatives on cocaine.

He added that while the focus is on cocaine, "we don't want to neglect the continuing problem of marijuana or the continuing problem of heroin addiction, even though there may be national emergencies associated with a particular drug."

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QUALITY AND ASSURANCE BUREAU SPEAKS OUT

Presently there are 37 state approved programs in existence. The care components are as follows: detoxification, 3; inpatient, 12 with 5 being hospital based and 7 free-standing; intermediate, 4; outpatient, 27 which includes 3 correctional facilities, and 26 ACT programs.

The average evaluation scores for FY86 is:

Administration	91.3%
Personnel	88.3%
Client Treatment	
Detox	74%
In-patient	87%
Hospital	88%
Freestanding	87%
Intermediate	66%
ACT	84%
Outpatient	86%

The common deficiencies are followup, accomplishment of goals and objectives, relationship between progress notes and treatment plan, quality of treatment plans, treatment updates, treatment plan assessments and the demonstration of effectiveness indicators.

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ADMISSION STATISTICS FOR FY 80-86

FY	Alcohol	Family	DUI
1980	3,664	1,020	884
1981	7,304	1,685	1,419
1982	8,143	1,615	2,342
1983	7,909	1,708	3,582
1984	8,705	2,652	4,178
1985	9,077	3,066	5,099
1986	7,573	3,249	4,125

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Among the employed 20-40 year olds, 29% reported use of an illicit drug in the past year and 19% reported some illicit drug use at least once in the past month.

From: Nida Capsules, Nov. 1986

NEW EMPLOYEE IN THE CHEMICAL DEPENDENCY FIELD

Bud Willard, director of the Lake County Chemical Dependency Program, states that he enthusiastically welcomes Adrienne Amen as a chemical abuse counselor to the staff. Adrienne started in this position on July 1, 1986 and has proven to be a valuable asset to the program.

Adrienne has an excellent background in human services to prepare her for a position with her present assignment as a chemical abuse counselor. She has a masters degree in communication and human relations, and has extensive experience in teaching, counseling, and personal and public relations. Just prior to her appointment with this program, she had been associated with Dr. Stephen Irwin of the Grandview Clinic in Polson and counseled in the Life Skills Practice part of the clinic. With her background and her personnel feelings about chemical abuse, Adrienne brings valuable experience and help to the clients of the program. She states, "I am dedicated to the idea that individuals and families can be helped".

If you have a new employee and want to toot their horn please send information to the Habit.

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COPING WITH A DRUG-USING PARENT

An estimated 6.5 million children under 18 in the United States have an alcoholic parent. No one knows for sure how many parents abuse prescription drugs, but the number is thought to be high: up to 20 percent of all doctors' prescriptions are for sedatives and tranquilizers. Those figures don't include the illegal drugs that some parents use.

"When Parental Guidance Isn't Suggested," an article by Elaine Radford published in the November 1986 issue of Listen, is a look at the problem of parental drug use through a teenager's eyes. It examines the difficulties a teen faces and the methods, good and bad, that are used to compensate. Radford talks about the reasons behind self-destructive behavior, strategies for coping with the situation, and where to get help.

All together, these explanations and suggestions form a short survival manual for the teenage child of an alcoholic/drug-using parent. Self-respect, confidence, and interpersonal skills are stressed.

Dr. Janet Woititz, author of the book Children of Alcoholics, points out that most children of alcoholic parents have low self-esteem. In "When Parental Guidance Isn't Suggested," Dr. Woititz explains that children frequently come to blame themselves for their parents' drug use. The resulting guilt feelings can be the basis for lifelong emotional problems if the child doesn't learn to cope with the situation.

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NEWLY CERTIFIED PERSONS

406	Mary Kay Bozman	Chemical Dependency
407	Steve Fairbank	Chemical Dependency
408	Robert Hubert	Chemical Dependency
409	Diana Morris Mann	Chemical Dependency
410	Lesa Pike	Management/Supervision
411	Claudia Montagne	Chemical Dependency
412	James R. Seymour	Chemical Dependency
413	Ted Szudera	Chemical Dependency
414	Joe Tobiness	Chemical Dependency Management/Supervision
415	Diane M. McLaverty	Chemical Dependency
416	Glenn Berg	Chemical Dependency
417	Anna Whiting	Management/Supervision
418	Dorothy L. Carl	Chemical Dependency
419	Harold Fisher, Sr.	Management/Supervision
420	Dick Petaja	Management/Supervision
421	Robert Graham	Prevention/Education Management/Supervision
354	Jack Pipe	Management/Supervision

The Center for Science in the Public Interest developed a survey in August 1986 in order to ascertain where laws for Alcohol Warning Signs were enacted in any states or cities. Following are the results of the survey.

FAS WARNING SIGN LAWS IN EFFECT AS OF OCTOBER 10, 1986

States: Georgia, South Dakota

Cities/Counties: New York City; Philadelphia; City and County of Los Angeles (*); Jacksonville and Leesburg, FL; Washington, DC; Columbus and Lakewood, OH; Oachita Parish, LA.

(*) The Los Angeles City ordinance has been challenged in Los Angeles Superior Court by the California Restaurant Association. The Association claims that only the State has the power under the California Constitution to regulate the commerce of alcoholic beverages.

FAS WARNING SIGN LAWS INTRODUCED, BUT DEFEATED

States: California, Arizona, Maine (The Governor of Maine, however, later issued an Executive Order requiring poster warnings in state liquor stores).

Cities/Counties: Buffalo, NY; Elyria, OH.

FAS WARNING SIGN LAWS INTRODUCED, BUT PENDING AS OF OCTOBER 10, 1986

New York State, New Jersey, Ohio

ESTIMATES OF THE NUMBER AND FREQUENCY OF FAS BIRTHS

Respondents reported a lack of data upon which to make these estimates. What was reported indicated a high degree of uncertainty and variability. Estimates of the frequency of FAS births ranged from 1/700 (New York) to 1/5,000 (Virginia), with other states (New Jersey, Utah, Maine, Connecticut and Alaska) holding closer to the national standard estimate of 1-3/1,000 live births per year. The estimated number of FAS cases also varied widely, ranging from 16 cases per year (Virginia), to 84 (Nebraska), to 179-537 (Illinois), to 860 (Texas).

ESTIMATED COSTS TO STATES DUE TO FAS BIRTHS

Very few respondents supplied this information. The responses included: $26,000 per victim per year (for mental retardation services alone) in Nebraska, with a total annual cost to the state of $2,184,000; a total annual cost of $241,074,430 in Texas; $43,680 per victim per year in New York, at a lifetime cost of $2,620,000 per child; $90,000 per victim per year (for costs of institutionalization) in Alaska; and, for 1980, $1.5 million of 18, and $760,000,000 total costs for FAS adults, in California.

The CSPI guide to passing legislation on FAS warning signs, referenced above, offers a formula to compute estimates of both numbers of births and costs of FAS for your area. We repeat it here: Nationally, estimates of the incidence of FAS births vary from 1 to 3 cases per 1,000, simply divide the number of live births in a given area by 1,000 to arrive at the number of FAS cases per year. Then multiply this number by $4,122 (the annual expected cost of treatment, according to the Research Triangle Corporation, which studied the economic costs to the nation of alcohol abuse) to estimate the annual additional costs of new FAS babies.

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Alcohol contributes to fatal disease, including cardiac myopathy, hypertension and stroke, pneumonia, several types of cancer, and liver disease.

From: CSPI, July, 1986

MONTANA'S CHEMICAL USE TREND

Rimrock Foundation polled private treatment facilities in Kalispell, Glasgow, Great Falls, Billings and Bozeman to see if Montana compares with the national statistics. These statistics are from a population of 463 adolescent patients and 304 Native Americans from the Thunderchild Alcoholism Treatment Center.

The average age for first use is eleven years with 10 years of age for Native Americans. Nationally 46 percent have abused chemicals by 13 years of age. In Montana 60% of adolescents interviewed had abused chemicals by 13 years and 80% of the Native American Youth.

Nationally, 69% of the youth interviewed were regular users of cocaine. With Montana that figure is 40%. The drugs of choice, nationally are alcohol, marijuana, amphetamines and cocaine. Montana uses these drugs but hallucinogens must be included with inhalants for the Native Americans.

Sixty per cent of the patients polled had experienced legal consequences. Major reasons given for the chemical use is peer pressure, to have fun and to fit in. Thirty-two percent said they used chemicals to escape.

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NATIONAL CAMPAIGNS AVAILABLE

Chemical People II: Generation At Risk

The documentary "Generation at Risk" will air January 28, 1987 at 8:00 p.m. on most PBS stations. This documentary profiles 10 communities that once suffered some of the worst statistics on teen problems and successfully turned them around.

The program will be hosted by First Lady Nancy Reagan and Sam Waterston (actor in "Killing Fields"). This is a sequel to the November, 1983 "Chemical People" which promoted the establishment of more than 8,000 community task forces to deal with teen chemical abuse.

"Generation at Risk" widens this concern to include not only chemical abuse but teen suicide, pregnancy and dropping out of school and how all these teen problems are interrelated. It is hoped that the energy focused on teen chemical abuse will expand to include the other problem areas and rejuvenate those task forces that have found themselves stagnant.

Some outreach options for task forces:

1. Teen Action Day (suggested date is Saturday, January 24, 1987); This would be a day long event that will offer opportunities for task forces, youth agencies and organizations to educate the communities on the resources available to teens in their area. Workshops, booths, an awards luncheon, fund raising events and exhibitions (bands, gymnastics, basketball game, martial arts, etc.) are some events you may want to include.

2. Town Meeting: Similar to "The Chemical People" where communities gather January 28 to watch "Generation at Risk" with a discussion following which pertains to that community and possible options to create a healthier community.

3. Speaker's Bureau: Talks about teens and the multiplicity of their problems and the need to have all of us work closer together for the benefit of all youth.

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Over three thousand babies are born yearly with severe birth defects associated with maternal drinking during pregnancy. This spectrum of serious birth defects -- known as Fetal Alcohol Syndrome -- includes facial disfiguration, a small head and body size, and mild to moderate mental retardation.

From: OSPI, July 1986

BE SMART! DON'T START!

Sponsored by NIAAA, Children's Television workshop and Macro Systems, this prevention effort will target the 16 million 8 to 12 year olds before they face intense peer pressures to use. The campaign will attempt to shape this age group's attitudes toward chemical usage.

The CBS/Broadcast Group has made a commitment to allocate a time slot between 8:00 and 8:15 p.m. (EST) for "Be Smart! Don't Start!" for PSAs beginning in April 1987. In addition, they have allocated another time slot for the PSAs on Saturday mornings, produce additional public service announcements involving CBS celebrities and incorporating the campaign messages and issues, where possible, in entertainment programs. The network will provide its affiliates with all campaign PSAs, the music video by "The Jets" and closed-circuit video materials.

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INFORMATION FOR THE HABIT

Generation At Risk

Hardin will be doing a teen action day. A teen dance is planned for the evening with lip sync contest. During the day, videos will be shown in downtown businesses pertaining to drug and alcohol issues.

During the week of January 28th, there will be an awareness day in Hardin High School and Middle School targeting the four critical teen issues. All classroom teachers will present subject matter relevant to their area of study. Some of the classes as language arts will be spending most of week with the project.

Hardin CITE organization has available three skits to use by groups doing cross-age tutoring. The Drug Wolf and the Three Little Pigs for K-3, A peer pressure skit for 4th through 6th and an intervention role play for 7th to adult. This skit is excellent for PAR presentation. All are available for $5. The money is used to support the positive peer pressure group, KIDS. For more information contact Hjordis Johnson, P.O. Box 202, Hardin, MT 59034.

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If you want to contribute to the Habit the next deadline is January 23, 1987.

Would you like to continue receiving the Habit? ____

Is the name and address correct? (If not please put corrections below with name and address.)

Our Dreams Are Within Our Reach

Within our reach
lies every path
we ever dream of taking.
Within our power
lies every step
we ever dream of making.
Within our range
lies every joy
we ever dream of seeing...
Within ourselves
lies everything
we ever dream of being

by Amanda Bradley

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